STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155781	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 01/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGCREST NURSING AND MEMORY CARE CENTER	915 S 27 ST SOUTH BEND, IN 46615

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS

 This visit was for the Post Survey Revisit (PSR) to the Investigation of Complaint #IN00118500.

Complaint #IN00118500 - Corrected

Survey Date: January 04, 2013

Facility number: 012199
Provider number: 155781
AIM number: 200989880

Survey team:
Julie Wagoner, RN

Census bed type:
SNF: 13
SNF/NF: 07
Total: 20

Census payor type:
Medicare: 04
Medicaid: 07
Other: 09
Total: 20

Sample: N/A

Morningcrest Nursing and Memory Care Center was found to be in compliance with 42 CFR part 483, Subpart B and 410 IAC 16.2 in regards to the PSR to the Investigation of Complaint #IN00118500.

Quality Review completed on 1/11/13, by Brenda Meredith R.N. | {F 000} | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE